ARIZONA MEDICAL BOARD
INITIAL LICENSE APPLICATION

9545 E Double Tree Ranch Rd., Scottsdale, AZ 85258
Phone: 480-551-2700 Fax: 480-551-2704

CC $500

RECEIVED
FEB 25 2011
AZ MEDICAL BOARD

To be completed and signed by applicant. All questions MUST be answered, even if only to indicate "None" or "N/A."

1. **First Name:** Maria **Middle Name:** Pia **Last Name:** Platia

Other Names Used: none

2. **Social Security Number:** [redacted] *No dashes*

3. **Date of Birth:** [redacted]

4. **City of Birth:** [redacted] **State of Birth:** [redacted] **OR** **Country of Birth:** [redacted]

Social Security Number, Date of Birth and Place of Birth are Confidential Information - Not for Public Disclosure

ADDRESSES:

Office Address: This is the office/principle place of business. The address and phone number will appear in the Medical Directory and on the Board's web site. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. If you want your home address to be listed on your web site profile, please so indicate. Otherwise, no address will be be provided on the profile, but it will be provided to the public if requested.

Mailing Address: Please provide a mailing address if different from Office or Home Address. If no address is provided, all Board correspondence will be sent to the Office Address.

Home Address: You are required to provide a home address and telephone number. They will not be released to the public *unless* you fail to provide an Office Address.

Email: This address is optional. If you provide an email address, it will not be released to the public.

5. **Office/Training Name:** Fertility and Gynecology Associates

Office/Training Address: 1 Pine East, 800 Spruce St. **City:** Philadelphia **State:** PA **Zip:** 19107

Email: [redacted] **Office Phone:** +1 (215) 829-6385 **Office Fax:** +1 (215) 829-6553

Mailing Address: 1 Pine East, 800 Spruce St. **City:** Philadelphia **State:** PA **Zip:** 19107

Home Address: [redacted] **City:** [redacted] **State:** [redacted] **Zip:** [redacted]

Home Phone: [redacted] **Mobile Phone:** [redacted]

ENTERED

6. PROOF OF CITIZENSHIP: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States. Federal law, 8 U.S.C. §1641 and State law, A.R.S. §1-501, require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona. Statement of Citizenship and Alien Status available on the website.

☒ **I am a U.S. Citizen or U.S. National.** (If this box is checked, please submit with your application a copy of one of the listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Public Benefits" i.e. Birth Certificate, U.S. Passport, etc.)

☐ **I am NOT a U.S. Citizen or U.S. National.** (If this box is checked, you must download, complete and submit with your application an "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents, such as an Alien Registration Card, Visa, etc.)

7. All states or provinces in which you *have or had* a license or registration. If more than five, attach a separate listing. If a license is pending or was not issued, so state. If none, please indicate "Not Applicable."

	State Board:	License No.:	License Status:
a.	Massachusetts	46979	Expired
b.	Maryland	D32614	Expired
c.	Dist. of Columbia	14427	Expired
d.	Pennsylvania	MD042869E	Active
e.			

8. Medical School Name: University of Pittsburgh School of Medicine

Medical School Location: Pittsburgh, PA **Graduation Date:** Jan 1, 1977

If you graduated from a medical school located outside the United States of America or Canada, please list below:

ECFMG No.: Certificate Date:

9. List chronologically, all internship, residency and fellowship training in the U.S. or Canada *(completed or not)*, or assistant professorship (or higher) at any programs attended, showing institution, address, type of program and dates. Attach a separate listing if needed.

	Institution:	City:	State:	Type of Program:	Dates of Attendance: From:	To:
a.	Montefiore Hospital and Medical Center	Bronx	NY	Internship	7/1977	6/1978
b.	Brigham and Women's Hospital	Boston	MA	Residency	7/1978	6/1981
c.	Brigham and Women's Hospital	Boston	PA	Fellowshp	7/1981	6/1983
d.						

First Name: Maria **Last Name:** Platia

10. License Exam. Please indicate all exams taken, the date(s) taken (month/day/year) and which state, if applicable:

☐ United States Medical Licensing Exam (USMLE): Step 3 Date: _____ State: _____

☐ State Written Examination: Date: _____ State: _____ *The Commonwealth of Puerto Rico is not accepted.*

☒ National Board of Medical Examiners Examination (NBME): Certification Date: 7/1/1978

☐ Federation of State Medical Boards Licensing Examination (FLEX): Date: _____

☐ Licentiate of the Medical Council of Canada (LMCC): Date: _____

☐ Special Purpose Examination (SPEX): Date: _____ State: _____

11. Indicate your area of interest and whether you are certified by the American Board of Medical Specialties (ABMS):

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
Obstetrics & Gynecology	☒ Yes ☐ No	☒ Yes ☐ No	Lifetime
Reproductive Endocrinology	☒ Yes ☐ No	☒ Yes ☐ No	Lifetime
	☐ Yes ☐ No	☐ Yes ☐ No	

12. Have you been in medical practice continuously for the past 10 years (or since graduation from medical school)? (If you mark "No," please submit a narrative explaining any lapses in practice (i.e. preparing for USMLE, sabbatical, etc.)

☒ **Yes** ☐ **No**

Explanation:

QUESTIONNAIRE

1. Have you had any application for any professional license refused or denied by any licensing authority? ☐ Yes ☒ No

2. Have you been refused or denied the privilege of taking an examination required for any professional licensure? ☐ Yes ☒ No

3. Have you been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled? ☐ Yes ☒ No

4. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently? ☐ Yes ☒ No

5. Have you voluntarily surrendered any healthcare license? ☐ Yes ☒ No

6. Have you had any healthcare license revoked? ☐ Yes ☒ No

7. Have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, license healthcare facility or healthcare staff of such facility? ☐ Yes ☒ No

8. Have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility? ☐ Yes ☒ No

9. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? "Disciplinary Action" includes, but is not limited to restriction, termination, voluntary or involuntary resignation or withdrawn. ☐ Yes ☒ No

10. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility? ☐ Yes ☒ No

11. Have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied, or have you surrendered or given up in lieu of action? ☐ Yes ☒ No

12. Have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, or misdemeanor involving moral turpitude? (See explanation below) *A "yes" answer is required even if you entered a diversion program.* ☐ Yes ☒ No

13. Have you been charged with or convicted (including a nolo contendre plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not the sentence was imposed or suspended? ☐ Yes ☒ No

14. In the last ten (10) years, has a judgment or settlement been entered against you as a defendent in a medical malpractice suit? *Please do not report pending malpractice suits or settlements paid not related to a civil action* ☐ Yes ☒ No

15. Have you been court martialed or discharged other than honorably from the armed service? ☐ Yes ☒ No

16. Have you been terminated from a healthcare position with a city, county, or state government or the Federal government? ☐ Yes ☒ No

17. Have you ever been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government? ☐ Yes ☒ No

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. In addition, you must submit photocopies of any corresponding documents, such as complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

First Name: Maria **Last Name:** Platia

CONFIDENTIAL QUESTIONNAIRE

1. Within the last five years, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?

2. Are you now being treated or have you in the last five years been treated for a drug or alcohol addiction or participated in a rehabilitation program? ***If in a confidential program in another state see explanation below.**

3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of healthcare providers and treatment centers where you were treated, along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past 5 years, pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with compliance reports from the state monitoring programs.

Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

First Name: Maria **Last Name:** Platia

RELEASE OF RECORDS:

☒ I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Arizona Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Medical Board or its successors to release to the organizations, individuals or groups listed above any information which is material to the application or any subsequent license.

ATTESTATION:

☒ **I ATTEST THAT ALL INFORMATION SUBMITTED ON AND WITH THIS APPLICATION IS TRUE.** I am the person herein named subscribing to this application; I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the application or to hold a hearing to revoke the license, if issued.

NOTE: Arizona law requires an applicant who has been charged with a felony or a misdemeanor involving conduct that may affect patient safety after submitting the application to notify the Board within 10 days after the charge is filed. A.R.S. §32-3208. For a list of reportable misdemeanors, see the website under Physician Center - Reportable Misdemeanors. All felonies are reportable.

☐ Check this box if you are using FCVS (Federation Credentials Verification Service)

In addition to your e-mail address provided on page one of this application please indicate if you would like to designate/ authorize ONE other individual beside yourself to receive status updates on your application:

Name Michael Bookman Phone# 215-715-1935 E-mail [redacted]

First Name: Maria **Last Name:** Platia

Signature: Maria Pia Platia **Date:** Feb 20, 2011

HOSPITAL AFFILIATION/CLINIC/MEDICAL EMPLOYMENT SUPPLEMENTAL FORM

of 2 pages

Please list all hospital affiliations within the past five (5) years, including moonlighting and courtesy staff affiliations. ***Do not*** include postgraduate training or self employment. List all medical employment, i.e. medical clinic, physician placement group, emergency medical group, radiology group, etc.

☐ Check here if you have not been employed within the past 5 years *(you are not required to submit a hospital/clinic affiliation verification or medical employment verification.)*

First Name: Maria **Last Name:** Platia

HOSPITAL/CLINIC AFFILIATION

a. Hospital/Clinic Name: Holy Redeemer Hospital and Medical Center From: 1990 To: present
Address: 1648 Huntingdon Pike City: Meadowbrook State: PA Zip: 19042
Position Held: attending physician

b. Hospital/Clinic Name: Abington Memorial Hospital From: 1991 To: present
Address: 1200 Old York Road City: Abington State: PA Zip: 19001
Position Held: attending physician

c. Hospital/Clinic Name: Pennsylvania Hospital From: 7/1999 To: present
Address: 800 Spruce Street City: Philadelphia State: PA Zip: 19107
Position Held: attending physician

MEDICAL EMPLOYMENT

a. Employer Name: Fertility and Gynecology Associates, PC From: 7/1/1999 To: present
Address: 1 Pine East, 800 Spruce Street City: Philadelphia State: PA Zip: 19107

b. Employer Name: From: To:
Address: City: State: Zip:

c. Employer Name: From: To:
Address: City: State: Zip:

All hospital/clinic affiliations and medical employment must be verified by the hospital/clinic or medical employer. Please forward the following two verification pages to the employers listed above and request that they be completed and returned directly to the Arizona Medical Board.

HOSPITAL AFFILIATION/CLINIC/MEDICAL EMPLOYMENT SUPPLEMENTAL FORM

of 2pages

Please list all hospital affiliations within the past five (5) years, including moonlighting and courtesy staff affiliations. ***Do not*** include postgraduate training or self employment. List all medical employment, i.e. medical clinic, physician placement group, emergency medical group, radiology group, etc.

☐ Check here if you have not been employed within the past 5 years *(you are not required to submit a hospital/clinic affiliation verification or medical employment verification.)*

First Name: Maria **Last Name:** Platia

HOSPITAL/CLINIC AFFILIATION

a. Hospital/Clinic Name: Thomas Jefferson University Hospital From: 12/1999 To: 6/30/2006
Address: 111 South 11th Street City: Philadelphia State: PA Zip: 19107
Position Held: attending physician

b. Hospital/Clinic Name: Jeanes Hospital From: 1/1999 To: present
Address: 7600 Central Ave City: Philadelphia State: PA Zip: 19111
Position Held: consulting physician

c. Hospital/Clinic Name: From: To:
Address: City: State: Zip:
Position Held:

MEDICAL EMPLOYMENT

a. Employer Name: From: To:
Address: City: State: Zip:

b. Employer Name: From: To:
Address: City: State: Zip:

c. Employer Name: From: To:
Address: City: State: Zip:

All hospital/clinic affiliations and medical employment must be verified by the hospital/clinic or medical employer. Please forward the following two verification pages to the employers listed above and request that they be completed and returned directly to the Arizona Medical Board.

ARIZONA MEDICAL BOARD
POSTGRADUATE TRAINING VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to obtain verification of all postgraduate training programs attended. This form must be completed by the **Program Director.** This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board. Authorization may be sent via mail or fax to 9545 E Doubletree Ranch Road, Scottsdale, AZ 85258 or (480) 551-2704.

First Name: Maria **Last Name:** Platia

Signature: Maria Pia Platia **Date:** 2/24/2011

Important - Program Participation: Report incomplete postgraduate years (PGY) separately from those that were successfully completed. If the postgraduate year is currently in progress, report the expected completion date in the "To" field. Report internships, residencies and fellowships separately.

PG Year: 1 **Department/Specialty:** Medicine

- [x] Internship
- [ ] Residency
- [ ] Fellowship
- [ ] Research

From: 07/01/77 **To:** 06/30/78

Successfully Completed? [x] Yes [ ] No [ ] In Progress

PG Year: **Department/Specialty:**

- [ ] Internship
- [ ] Residency
- [ ] Fellowship
- [ ] Research

From: **To:**

Successfully Completed? [ ] Yes [ ] No [ ] In Progress

PG Year: **Department/Specialty:**

- [ ] Internship
- [ ] Residency
- [ ] Fellowship
- [ ] Research

From: **To:**

Successfully Completed? [ ] Yes [ ] No [ ] In Progress

Affix Training Program Seal Here

1. **This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Examination Education (ACGME), or the Royal College of Physicians and Surgeons of Canada:** [x] Yes [ ] No
2. **Did this individual ever take a leave of absence or break from training?** [ ] Yes [ ] No *(If yes, please explain below)*
3. **Was this individual disciplined and/or placed under investigation or on probation?** [ ] Yes [ ] No *(If yes, please explain below)*

Please see attached letter.

Written Explanation: Please see attached letter.

Program Name: Albert Einstein College of Medicine/ Montefiore Medical Center **Name/Title:** Philip D. Lief, MD Vice Chair for Clinical Affairs/Program Director

Address: 111 E. 210th Street **City:** Bronx **State:** NY **Zip:** 10467

Phone: 718-920-6097 **Fax:** 718-20-8375 **Signature:**

MONTEFIORE MEDICAL CENTER
The University Hospital for the Albert Einstein College of Medicine
Henry and Lucy Moses Division

111 East 210th Street
Bronx, New York 10467-2490
718-

MONTEFIORE

March 23, 2011

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Re: Maria Pia Platia, MD

To Whom It May Concern:

Please let this letter serve as verification that Maria Pia Platia, MD attended the Albert Einstein College of Medicine/Montefiore Medical Center Internal Medicine Residency Training Program. She entered our program on July 1, 1977, and she completed the program on June 30, 1978.

Please be aware that records of graduates of our Internal Medicine Residency program greater than ten years are not available to us. We can only verify training dates.

Thank you for your understanding in this matter.

Sincerely,

Philip D. Lief, MD
Program Director - Internal Medicine
Montefiore Medical Center
Professor of Medicine
Albert Einstein College of Medicine

PL:sh

ARIZONA MEDICAL BOARD MEDICAL COLLEGE VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to submit verification of all medical schools attended. This form must be completed by the medical school **Dean or the Registrar.** This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board. Authorization may be sent via mail or fax to 9545 E Doubletree Ranch Road, Scottsdale, AZ 85258 or (480) 551-2704.

First Name: Maria **Last Name:** Platia

Signature: Maria Pia Platia **Date:** 2/24/2011

1. **This is to certify that the applicant listed above was enrolled at (name of college):** University Of Pittsburgh School of Medicine

Located in: City: Pittsburgh State: PA

2. **The undersigned further certifies that the records of this institution show that the applicant attended this institution:** From: 09/05/1973 To: 05/21/1977

3. **Please check one:** ☑ The applicant was granted a medical degree by the above named school on: 05/26/1977

☐ The applicant withdrew from the above named school on:

4. **Advanced Credits Granted Upon Admission:**

Medical School: *Total Credits:* *Dates Attended:* From: To:

Name/Title: Kim Kirk Asst. Records Officer

Address: 3550 Terrace Dr. Pittsburgh PA 15261 City: Pittsburgh State: PA Zip: 15261

Phone: 412-648-9239 Fax: 412-624-0290

Signature: Kim Kirk

Affix Seal of College Here

BRIGHAM AND WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

Due to the increase in requests for information regarding former and current Brigham and Women's Hospital medical staff members, we regret that we are unable to complete the form that you have sent to us. The information provided below satisfies the Massachusetts Board of Registration in Medicine requirements for reasonable inquiries, as stated in Regulation 243 CMR 3.05. To the best of our knowledge, this information is accurate and current.

PHYSICIAN'S NAME: Maria Pia Platia, MD

DEPARTMENT: OB/GYN

STAFF CATEGORY:

Intern:	From:_____	To:
Resident:	From: 7/01/78	To: 6/30/81
Clinical Fellow:	From: 7/01/81	To: 6/30/83
Active Staff:	From:_____	To:

CLINICAL PERFORMANCE: To the best of our knowledge, Dr. Platia continues to meet or exceed all clinical performance requirements to qualify for reappointment at Brigham and Women's Hospital.

PROFESSIONAL PERFORMANCE / DISCIPLINARY ACTION: To the best of our knowledge, there are no issues relating to performance, character, or competence that would deny his/her (re) appointment nor any pending or closed disciplinary actions.

LIABILITY CLAIMS: Contact insurer.

Robert Barbieri 3-3-11

Name: Robert L. Barbieri, M.D. Date

Title: Chairman, Department of Obstetrics & Gynecology

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Endorsement of Certification

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Recipient: Arizona Board of Medical Examiners
9545 E Doubletree Ranch Road
Scottsdale, AZ 85258-5514

Date: 02/24/2011

Examinee: Maria Pia Platia

Examinee ID: 3-182-890-8
Date of Birth: [redacted]

NBME Certification Date: 07/01/1978

Certificate#: 182890

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It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores: Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/10/1975	Pass	Three-Digit	610	(380)	470	570	620	710	575	585	610
		Two-Digit	86	(75)	79	85	88	94	85	86	88

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores: Med	Surg	ObGyn	Prev	Peds	Psych
09/28/1976	Pass	Three-Digit	635	(290)	635	575	665	565	580	630
		Two-Digit	87	(75)	89	86	90	85	86	88

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/08/1978	Pass	Three-Digit	450	(290)
		Two-Digit	80.3	(75)

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

CK 4681

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APR 21 2011
AZ MEDICAL BOARD

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov

April 15, 2011

Maria Pia Platia, M.D.
1 Pine East
800 Spruce Street
Philadelphia, PA 19107

Dear Dr. Platia,

The Arizona Medical Board is pleased to inform you that your application for licensure in the State of Arizona is administratively complete and has been approved. Your license #44615 will be issued upon receipt of the required statutory license registration fee A.R.S. § 32-1436(A)(2) and **is renewable on your birthday on** [redacted]

As of January 2001 Arizona converted to biennial licensure based on birth month and odd or even birth year. **Your required license registration fee is $187.50**. This fee is your licensing fee and is in addition to the $500.00 application processing fee that you have already paid.

Please complete the bottom portion of this letter and return the completed form with the initial license registration fee payable to the Arizona Medical Board, 9545 E. Doubletree Ranch Rd., Scottsdale, AZ 85258. If paying by credit card, the completed form along with the payment card authorization must be returned. NOTE: The residential address and phone number are not available to the public unless they are the only address and number of record. You are not permitted to commence the practice of medicine in the State of Arizona until your license has been issued. **Allow up to 5 business days for the processing of your payment and issuance of your license. Please do not call and request status, as this will slow down the process.**

Registration forms and initial license fees not returned **postmarked within thirty-five days** of this notice will result in the application being withdrawn and applicant will be required to reapply.

If you have any questions, please contact me by e-mail at sgrabe@azmd.gov or by telephone at (480) 551-2756.

Sincerely,

Suzann Grabe
Licensing Office Manager

(DO NOT DETACH)

Name: Maria Pia Platia

Current Office Address: 1 Pine East, 800 Spruce St. Philadelphia PA 9107

Current Home Address: [redacted]

Current Mailing Address [redacted]

Current Office Telephone 215-829-6385 Current Home Telephone [redacted]

Current Office E-Mail 215-829-6553 Current Home E-Mail [redacted]

Area of Interest: OB/GYN, Reproductive Endocrinology/Infertility Practicing: ☒ Yes ☐ No

NOTE: Statutes require you to provide the Board with written notification within thirty days (30) of any changes in addresses or phone numbers.

Arizona Medical Board
9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Fax: 480-551-2704
Website: www.azmd.gov

March 14, 2011

Maria Pia Platia, M.D.
1 Pine East
800 Spruce Street
Philadelphia, PA 19107

Dear Dr. Platia:

This will acknowledge receipt of your application for licensure to practice medicine in the State of Arizona.
I have reviewed your application. To complete the processing of your application, the following documentation is still required:

1) **District of Columbia licensure verification (status and disciplinary actions)**
2) **Postgraduate Training Verification from Montefiore Hospital and Medical Center for the time period of 7/77 to 6/78**
3) **Hospital Affiliation Verification from Jeanes Hospital**

Please be advised final action cannot be taken until the required information is in your application file. It is your responsibility to ensure that the Board receives all documentation.

Further, please be advised that if your application is not fully complete within one year from this date, including participation in written SPEX/USMLE Examination (if applicable), your application is deemed withdrawn.

Should your application be approved, you will be notified of the initial licensing fee due for issuance of your license.

If you have any questions, please contact me by e-mail at: Tenley.Oberhaus@azmd.gov or by phone at (480) 551-2724.

Sincerely,

Tenley Oberhaus
Licensing Coordinator

Arizona Medical Board: License Renewal Questions

Maria Platia 2011 License # 44615 Professional Conduct

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	**No**	
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	**No**	
3. Since your last renewal have you voluntarily surrendered any healthcare license?	**No**	
4. Since your last renewal have you had any healthcare license revoked?	**No**	
5. Since your last renewal have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**No**	
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**No**	
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? -Disciplinary Action- includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn.	**No**	
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	**No**	
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A -yes- answer is required even if you entered a diversion program.	**No**	
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	**No**	
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	**No**	
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	**No**	
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	**No**	

Arizona Medical Board: License Renewal Questions

Maria	Platia	2011	License # 44615	Mental Health

1. Since your last renewal, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?	[redacted]
2. Are you now being treated or since your last renewal have you been treated or for a drug or alcohol addiction or participated in a rehabilitation program? *If in a confidential program in another state see explanation below	
3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1)behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? See below for definition of ability to practice medicine.	

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LOGIN

Maria Pia Platia, M.D.

Status as of 11/27/2013

Below are all certifications held by this physician with ABOG.

ABOG ID: 815112
Elkins Park, PA

Obstetrics and Gynecology Certification		
Original Certification Date	Certification Status	Meeting Requirements of Maintenance of Certification
12/1/1985	Non-Expiring	Not required at this time

Subspecialty Certification Reproductive Endocrinology and Infertility		
Original Certification Date	Certification Status	Meeting Requirements of Maintenance of Certification
2/1/1987	Non-Expiring	Not required at this time

Search Again

To purchase a copy of this status information sent from ABOG

Purchase Status Letter

The letter will contain the information above
and be sent directly to an address of your choosing

Proceed with Payment

ARIZONA MEDICAL BOARD
MD RENEWAL
CONFIDENTIAL QUESTION ADDENDUM

Revised 12/2/15

9545 E. Doubletree Ranch Rd., Scottsdale, AZ 85258
www.azmd.gov; Email: licensingreport@azmd.gov

Questionnaire

1. Since 2009, Have you been found guilty or entered into a plea of no contest to a felony, a misdemeanor involving moral turpitude, or an alcohol or drug related offense in any state?

[redacted]

2. Have you received treatment within the last five years for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to exercise the judgement and skills of a medical professional? If so, provide the following:

[redacted]

A.) A detailed description of the use, disorder, or condition; and

B.) An explanation of whether the use, disorder, or condition is reduced or ameliorated because you receive ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating.

C.) A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.

The purpose of the confidential question is to allow the Board to determine the applicant's current fitness to perform health care tasks. The mere fact of treatment, monitoring or participation in a support group is not, in itself, a basis of which admission is denied; the Board routinely licenses individuals who demonstrate personal responsibility and maturity in dealing with fitness issues. The Board encourages those applicants who may benefit from assistance to seek it. The Board may limit or deny licensure to applicants whose ability to function is impaired in a manner relevant to the practice of medicine at the time the licensing decision is made or to applicants who demonstrate a lack of candor by their responses. This is consistent with the public purpose that underlies the licensing responsibilities assigned to the Arizona Medical Board and to the applicants seeking licensure.

I attest that all of the information contained in the application and accompanying evidence or other credentials submitted are true. I attest the credentials submitted with the application were procured without fraud or misrepresentation or any mistake of which I am aware, and that I am the lawful holder of the credentials. I authorize the release of any information from any source requested by the Board necessary for initial and continued licensure in this state.

Full Name (Please Print): Maria Pia Platia **Signature:** Maria Pia Platia

Date: 12-18-15

Moral Turpitude includes but is not limited to: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Embezzlement, Fabricating and Presenting False Public Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting, Theft and soliciting prostitution.

From: [redacted]
To: Tiffany Thornhill
Subject: MD license renewal
Date: Friday, December 18, 2015 7:44:51 PM
Attachments: [redacted]

Hello Tiffany,

I've attached the filled and signed form you sent for license renewal as well as scan of AZ Driver's License. Let me know if all is complete.

Thanks and Happy Holidays!

Maria Pia Platia, M.D.
[redacted]

Arizona Medical Board

9545 E. Doubletree Ranch Road, Scottsdale AZ 85258 • website: www.azmd.gov
Phone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2707

December 18, 2015

***** sent via email and US Mail***

Dr. Maria Platia
[redacted]

[redacted]

This will acknowledge receipt of your renewal application for licensure to practice medicine in the State of Arizona. At the time of renewal, all files are reviewed for completeness. If it is determined that anything is missing, it is requested at this time.

To complete the processing of your renewal application, the following documentation is still needed:

1.) **Please complete attached application addendum.** (this is an updated questionnaire, please complete and return)
2.) **Please provide government issued document that contains a photograph**. (ie: passport, driver's license)

*****Please do NOT fax photos; they do not come across clear. Scanned copies or pictures of the photo may be emailed or mailed*****

PLEASE NOTE: If the above items are not received within 60 days of this notice, your Arizona Medical License will expire on its scheduled expiration DATE. Any items that are received after the 60 day period will not be accepted. If your license expires you may reapply as an initial applicant.

Should you wish to appeal any item in this deficiency letter you must submit your request for a hearing to the Board pursuant to AAC R4-16-206(B)(2) within 30 days from the date of this notice.

A.R.S. § 32-1430:
B. A person renewing an active license to practice medicine in this state shall provide to the board as part of the renewal process a report of disciplinary actions, restrictions or any other action placed on or against that person's license or practice by another state licensing or disciplinary board or an agency of the federal government. This action may include denying a license or failing the special purpose licensing examination. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action taken.
C. The licensee shall submit proof with the renewal form of having completed a training unit as prescribed by the board relating to the requirements of this chapter and board rules.
D. A person whose license has expired may reapply for a license to practice medicine as provided in this chapter.

R4-16-207. Time-frames for License Renewal; Expiration
B. For license renewal, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 45 days and begins on the date the Board receives the renewal application.
1. If the required application is not administratively complete, the Board shall send a written deficiency notice to the applicant.
a. In a deficiency notice, the Board shall state each deficiency and the information required to complete the application or supporting documentation.
b. Within 60 days after the Board sends a deficiency notice, the applicant shall submit to the Board the requested documentation or information specified in the notice. The time-frame for the Board to finish the administrative completeness review is suspended from the date of the notice until the date the Board receives the requested documentation or information from the applicant.
D. If a person holding an active license does not apply for license renewal according to the biennial renewal requirement or fails to meet time-frame requirements under this Section, the person's license expires according to provisions prescribed under A.R.S § 32-1430(A) unless the person is under investigation according to provisions prescribed under A.R.S. § 32-3202.

Tiffany Thornhill
Arizona Medical Board
Licensing Renewal Coordinator
Tiffany.Thornhill@azmd.gov

AMB - Physician Renewal - Confirmation (Step 8 of 11)

11/23/2015

Dr. Maria Pia Platia

Please review the information below and click at the bottom to accept. If you need to correct the information, click the links below the records.

General Questions

Note: ***In the event the response to any of the questions numbered 1 through 10 is â€œYESâ€***, you must file by fax or mail a detailed report concerning the below matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

1) Since 2009, have you had an application for medical licensure denied or rejected by another state or province licensing board? If so, provide an explanation.

No

2) Since 2009, has any disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions? If so, provide an explanation.

No

3) Since 2009, have any disciplinary actions, restrictions or limitations taken against you while participating in any type of program or by any health care provider? If so, provide an explanation.

No

4) Since 2009, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation, during an investigation or entered into a consent agreement or stipulation? If so, provide an explanation.

No

5) Since 2009, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation.

No

6) Since 2009, Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? If so, provide an explanation.

No

7) Since 2009, have you had your authority to prescribe, dispense, or administer medications limited, restricted,

modified, denied, surrendered, or revoked by a federal or state agency? If so, provide an explanation.

No

8) Since 2009, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? If so, provide an explanation.

[redacted]

9) Since 2009, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? Is so, provide an explanation. See list of Moral Turpitude items at .

No

10) Since 2009, have you failed the special purpose licensing examination (SPEX)?

No

Physical/Mental Health and Substance Abuse Questions

In the event you answer YES to any of the below questions, you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of healthcare providers and treatment centers where you were treated, along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past 5 years pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of physician assistantâ€™s impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with a compliance reports from the state monitoring programs

FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.

1) Since 2009, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including diagnosis or treatment for any psychotic disorder or substance abuse disorder? If so, provide an explanation.

[redacted]

2) Since 2009, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional? If so, provide an explanation

[redacted]

Citizenship Status

I am a U.S. Citizen or U.S. National

Specialties

	Specialty	Certified?	Practicing?	Date Certified	Expiration Date
Primary Specialty	Obstetrics & Gynecology	Yes	Yes	12/01/1985	
Specialty 2	Reproductive Endocrinology/Infertility (Obstetrics & Gynecology)	Yes	Yes	02/01/1987	
Specialty 3					
Specialty 4					

Practice Address

Maria Pia Platia, M.d.

[redacted]

You are required to enter a valid address, if you have one.

Home Address

[redacted]

You are required to enter a valid address, if you have one.

Mailing Address

Maria Pia Platia, M.d.

[redacted]

[redacted]

You are required to enter a valid address, if you have one.

Please review all information you have provided. Change any information given or click on the I Agree button to verify that all information posted above is correct and to proceed to payment options.

By agreeing with this data, you are signing this registration form and certifying under pentalty of perjury that all information on this form is currently accurate and:

· I am a U.S. Citizen or a qualified/registered alien

· I have completed a minimum of 40 credit hours of continuing medical education during the two calendar years preceding renewal year as required by A.R.S. Â§32-1434 and A.A.C. Â§ R4-16-101

· I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close as required by A.R.S. Â§32-3211.

I Agree | **Yes** **No**

MD Training Unit

Complete

You may wish to print this Page for your records.

After pressing the ***Next*** button, please be patient, as it may take a few moments to process your data and send you to the payment page.

10019181 . 2/001454

128/527 1 : 7 PLATIA, MARIA P. MD [redacted]

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	03-31-2019	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	09-27-2016

PLATIA, MARIA P. MD
1250 E. APACHE
#108
TEMPE, AZ 85281-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
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DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
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Form DEA-223 (4/07)

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	03-31-2019	$731

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	02-21-2016

PLATIA, MARIA P MD
PLANNED PARENTHOOD OF AZ
5771 WEST EUGIE AVE
GLENDALE, AZ 85304

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C, 20537

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WASHINGTON, D.C, 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	03-31-2019	$731

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	02-21-2016

PLATIA, MARIA P MD
PLANNED PARENTHOOD OF AZ
5771 WEST EUGIE AVE
GLENDALE, AZ 85304

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Form DEA-223 (05/04)

10018845.2/002104

134/519 1: PLATIA, MARIA P MD [redacted]

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	03-31-2019	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	09-27-2016

PLATIA, MARIA P MD
5240 E KNIGHT DR
#112
TUCSON, AZ 85712-8571

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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UNITED STATES DEPARTMENT OF JUSTICE
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WASHINGTON D.C. 20537

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SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
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PLATIA, MARIA P MD
5240 E KNIGHT DR
#112
TUCSON, AZ 85712-8571

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Form DEA-223 (4/07)

CC $200

RECEIVED
AUG 19 2016
ARIZONA MEDICAL BOARD

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2707
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

RECEIVED
AUG 22 2016
ARIZONA MEDICAL BOARD

PHYSICIAN NAME: Maria Pia Platia

LICENSE #: 44615 SPECIALTY: Obstetrics & Gynecology

CHECK ONE: X Initial Registration ($200) Renewal Registration ($150)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE

A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period

PRIMARY PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
1250 E. Apache #108				Tempe, AZ 85281			
Phone Number				Fax Number		[redacted]	
480-966-4728				480-921-8712			
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs		Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

***** List any additional locations on the 2nd page of this form and place a check mark here: ☐

Physician's Signature: Maria Pia Platia Date: 8/19/2016

Initial registration fee: $200.00 per physician Renewal registration fee: $150.00 per physician

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa, MasterCard or American Express

If you wish to pay by payment card, please complete the attached
PAYMENT CARD AUTHORIZATION FORM

ENTERED

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2707
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Maria Pia Platia

LICENSE #: 44615 SPECIALTY: Obstetrics & Gynecology

CHECK ONE: X Initial Registration ($200) Renewal Registration ($150)

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PRIMARY PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
5240 E. Knight Dr., #112				Tucson, AZ 85712			
Phone Number				**Fax Number**		[redacted]	
520-323-9210				520-323-9689			
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs		Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

***** List any additional locations on the 2nd page of this form and place a check mark here: ☐

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ARIZONA MEDICAL BOARD

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DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Maria Pia Platia

LICENSE #: 44615 SPECIALTY: Obstetrics & Gynecology

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PRIMARY PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
5771 W. Eugie Ave				Glendale, AZ 85304			
Phone Number				Fax Number		[redacted]	
623-934-7006				623-937-3014			
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs		Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

***** List any additional locations on the 2nd page of this form and place a check mark here: ☐

Physician's Signature: Maria Pia Platia Date: 8/19/2016

Initial registration fee: $200.00 *per physician* **Renewal registration fee: $150.00 *per physician***

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa, MasterCard or American Express

If you wish to pay by payment card, please complete the attached
PAYMENT CARD AUTHORIZATION FORM

Planned Parenthood®
Care. No matter what.

Planned Parenthood Arizona, Inc.

FAX TRANSMITTAL

Date: August 19, 2016 Fax No.: 480-551-2707

To: Arizona Medical Board No. of pages: 7 (including cover)

From: Planned Parenthood Arizona Phone No.: 602-200-2145

Comments:

Dispensing Physician Initial Registration forms for Maria Pia Platia, MD.

Please contact Gretchen Parham at 602-200-2129 or Kate Thomas at 602-200-2145 if you have any questions. Thank you.

Planned Parenthood Arizona
4751 N. 15th Street
Phoenix, AZ 85014

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2707
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: MARIA PIA PLATIA

LICENSE #: 44615 SPECIALTY: Obstetrics & Gynecology

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Street Address				City/State/Zip Code	
5771 W. Eugie Ave				Glendale, AZ 85304	
Phone Number				Fax Number	
623-934-7006				623-937-3014	[redacted]
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs	✓
Schedule IV Drugs		Schedule V Drugs		Prescription Devices	✓

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code	
1250 E. Apache #108				Tempe, AZ 85281	
Phone Number				Fax Number	
480-966-4726				480-921-8712	[redacted]
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs	✓
Schedule IV Drugs		Schedule V Drugs		Prescription Devices	✓

***** List any additional locations on the 2nd page of this form and place a check mark here: [X]

Physician's Signature: Maria Pia Platia Date: 9/22/16

Initial registration fee: $200.00 *per physician* **Renewal registration fee: $150.00 *per physician***

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa, MasterCard or American Express

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
5240 E. Knight Dr. #112				Tucson, AZ 85712			
Phone Number				**Fax Number**		**E Mail**	
520-323-9210				520-323-9689		[redacted]	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs	✓	Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices	✓		

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				**Fax Number**		**E Mail**	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				**Fax Number**		**E Mail**	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				**Fax Number**		**E Mail**	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				**Fax Number**		**E Mail**	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				**Fax Number**		**E Mail**	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			